Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: INJURY ONE TREATMENT CENTER PHYSICIAN MANAGEMENT SERVICES 5445 LA SIERRA DRIVE #204 DALLAS TX 75213	MFDR Tracking #:	M4-08-6083-02
	Previous MFDR Tracking #:	M4-08-6083-01
	DWC Claim #:	
	Injured Employee:	
Respondent Name and Box #: STATE OFFICE OF RISK MANAGEMENT Box #: 45	Date of Injury:	
	Employer Name:	
	Insurance Carrier #:	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "…The patient was referred for individual psychotherapy & Physical Therapy. The claims were denied per EOB denied per IME. Per TWCC Rule 133.301(a), the insurance carrier shall not retrospectively review the medical necessity of a medical bill for treatment(s) and/or service(s) for which the medical care provider has obtained preauthorization under Rule 134.600(h). The services that were provided were preauthorization [sic], #628719, #631211 & #633652 therefore they were deemed medically necessary. Also, the treatment that was provided is part of his compensable injury to his knee that he sustained on 07/14/05…."

Principal Documentation:

1. DWC 60 Package
2. Medical Bill(s)
3. EOB(s)
4. Medical Records
5. Total Amount Sought - $3,683.24

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary dated June 16, 2008, states in part, "…the office will maintain its denial for B22-Payment adjusted based on diagnosis and W-12-Extent of Injury. Not finally adjudicated.

The Office filed a PLN-11 (Exhibit I, II & III) disputing the liability or disability for treatment of Meniscal degeneration, cartilage loss, bone on bone articulation, subchondral sclerosis, bone edema, internal derangement, DVT, vascular insufficiency, and degenerative changes of the knees.

The Division ordered a designated doctor's exam to assess the compensable injury and it was reported on January 29, 2008 (Exhibit IV) by Dr. Peter Cuniowski that the claimant's compensable injury appears to be bilateral knee contusions, intractable knee pain bilaterally and major depression.

The Office respectfully requests the Division deem the dates of service 5/18/07-6/1/07 reference above ineligible for medical dispute resolution pursuant to Rule 133.307 (I) (A)…."

Principal Documentation:

1. Response Package
2. Copies of PLN11's

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
5/18/07	90801	$183.81	$0
5/21/07	97001	$83.73	$0
5/31/07	G0283	$13.04	$0
5/31/07	97530	$100.29	$0
5/31/07	97535	$100.29	$0
6/1/07	G0283	$13.04	$0
6/1/07	97035	$12.13	$0
6/1/07	97110	$94.50	$0
6/7/07	G0283	$13.04	$0
6/7/07	97035	$12.13	$0
6/7/07	97110	$126.00	$0
6/14/07	97110	$157.50	$0
6/15/07	97035	$12.13	$0
6/15/07	G0283	$13.04	$0
6/15/07	97110	$94.50	$0
6/20/07	97035	$12.13	$0
6/20/07	G0283	$13.04	$0
6/20/07	97110	$94.50	$0
6/21/07	90806	$108.31	$0
6/21/07	90880	$133.71	$0
6/21/07	97035	$12.13	$0
6/21/07	G0283	$13.04	$0
6/21/07	97110	$189.00	$0
6/29/07	90806	$108.31	$0
6/29/07	90880	$133.71	$0
6/29/07	97002	$44.28	$0
6/29/07	J1100	$12.13	$0
6/29/07	G0283	$26.08	$0
6/29/07	97035	$12.13	$0
6/29/07	97530	$33.43	$0
7/6/07	G0283	$108.31	$0
7/6/07	97110	$133.71	$0
7/6/07	96151	$61.30	$0
7/12/07	G0283	$13.04	$0
7/12/07	97110	$126.00	$0
7/13/07	97035	$12.13	$0
7/13/07	G0283	$13.04	$0
7/13/07	97110	$157.50	$0
7/17/07	90806	$108.31	$0
7/17/07	90880	$133.71	$0
7/19/07	97035	$12.13	$0
7/19/07	G0283	$13.04	$0
7/19/07	97110	$94.50	$0
7/20/07	97002	$44.28	$0

7/20/07	J1100	$12.13	$0
7/20/07	97035	$12.13	$0
7/20/07	G0283	$13.04	$0
7/20/07	97110	$94.50	$0
8/1/07	90806	$108.31	$0
8/1/07	90880	$133.71	$0
8/8/07	90806	$108.31	$0
8/8/07	90880	$133.71	$0
8/8/07	96151	$61.30	$0
		Total Due:	$0

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Tex. Lab. Code Ann. §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedure for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code § 134.202 sets out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after September 1, 2002.
3. 28 Tex. Admin. Code §134.600 sets out the preauthorization guidelines.
4. 28 Tex. Admin. Code §133.305 sets out the general procedure for Medical Dispute Resolution
5. The services in dispute were reduced/denied by the carrier with the following reason codes:

Disputed DOS: 5/18/2007
No EOBS were submitted by the requestor

Disputed DOS: 5/21/07
Disputed CPT code(s): 97001
EOB dated 10/2/07:

- 074-Denied per IME
- W4-No Additional payment allowed after review
- T14-Appeal denied on med. Necessity-IRO info below
- Per IME injury has resolved and does not require further treatment to include physical therapy therefore a PT eval would not be necessary

Disputed DOS: 5/31/07
Disputed CPT code(s): G0283, 97530, 97535
EOB dated 8/30/07:

- 074-Denied per IME
- W1-Workers' compensation state fee schedule adj

EOB dated 12/5/07:

- 074-Denied per IME
- 50-Service not deemed "Medically Necessary" by payer
- W4-No additional payment allowed after review

Disputed DOS: 6/7/07
Disputed CPT code(s): G0283, 97035, 97110
EOB dated 8/30/07:

- 074-Denied per IME
- W4-No Additional payment allowed after review

EOB dated 12/5/07:

- 074-Denied per IME
- 50-Service not deemed "Medically Necessary" by payer
- W4-No additional payment allowed after review

Disputed DOS: 6/14/07
Disputed CPT code(s): 97110
EOB dated 9/19/07:

- B22-Payment adjusted based on diagnosis

EOB dated 11/2/07:

- W4-No Additional payment allowed after review
- B22-Payment adjusted based on diagnosis
- Per IME original injury has resolved, claimant is treating for degenerative conditions which are not related to original injury.

Disputed DOS: 6/15/07
Disputed CPT code(s): 97035, G0283, 97110
EOB dated 8/30/07:

- 074-Denied per IME
- W1-Workers' compensation state fee schedule adj

EOB dated 11/2/07:

- W4-No Additional payment allowed after review
- B22-Payment adjusted based on diagnosis
- Per IME original injury has resolved, claimant is treating for degenerative conditions which are not related to original injury.

Disputed DOS: 6/20/04
Disputed CPT code(s): 97035, G0283, 97110
EOB dated 9/18/07:

- 074-Denied per IME
- W1-Workers' compensation state fee schedule adj

EOB dated 11/02/07:

- W4-No Additional payment allowed after review
- B22-Payment adjusted based on diagnosis
- Per IME original injury has resolved, claimant is treating for degenerative conditions which are not related to original injury.

Disputed DOS: 6/21/07
Disputed CPT code(s): 90806, 90880, 97035, G0283
EOB dated 8/30/07:

- B13-Payment for service may have been previously paid
- B22-Payment adjusted based on diagnosis
- W1-Workers' compensation state fee schedule adj
- B15-Procedure/Service is not paid separately

EOB dated 9/24/07:
Disputed CPT code(s): 97110

- B22-Payment adjusted based on diagnosis
- W1-Workers' compensation state fee schedule adj
- Injury is knee contusions only; carrier is disputing all degenerative conditions of the knee and internal derangement of the knee it appears that the treatment is not related to the accepted wc injury.

Disputed DOS: 6/29/07
Disputed CPT code(s): 90806, 90880, 90889, 97002, J1100
EOB dated 8/30/07:

- 50-Service not deemed "Medically Necessary" by payer
- B22-Payment adjusted based on diagnosis
- W1-Workers' compensation state fee schedule adj
- B15-Procedure/Service is not paid separately
- T14-Medical necessity denial. Appeal within 11 mos of DOS

EOB dated 9/24/07:
Disputed CPT code(s): G0283, 97035, 97530

- B22-Payment adjusted based on diagnosis
- W1-Workers' compensation state fee schedule adj
- Injury is knee contusions only carrier is disputing all degenerative conditions of the knee and internal derangement of the knee. It appears that the treatment is not related to the accepted wc injury.

Disputed DOS: 7/6/07
Disputed CPT code(s): 90806, 90880, 96151
EOB dated 8/30/07:

- 074-Denied per IME
- W11-Entitlement to benefits. Not finally adjudicated
- B15-Procedure/Service is not paid separately

EOB dated 12/5/07:

- W4-No Additional payment allowed after review
- W12-Extent of injury. Not finally adjudicated
- Carrier disputes treatment and/or liability for depression, anxiety and/or any other psychological conditions.
- Per the IME, the injury has resolved.

Disputed DOS: 7/12/07
Disputed CPT code(s): G0283, 97110
EOB dated 8/30/07:

- 074-Denied per IME
- W11-Entitlement to benefits. Not finally adjudicated

EOB dated 12/5/07:

- 074-Denied per IME
- 50-Service not deemed "Medically Necessary" by payer
- W4-No additional payment allowed after review

Disputed DOS: 7/13/07
Disputed CPT code(s): 97035, G0283, 97110
EOB dated 8/30/07:

- 074-Denied per IME
- W1-Workers' compensation state fee schedule adj

EOB dated 12/5/07:

- 074-Denied per IME
- 50-Service not deemed "Medically Necessary" by payer
- W4-No additional payment allowed after review.

Disputed DOS: 7/17/07
Disputed CPT code(s): 90806, 90880
EOB dated 8/30/07:

- W1-Workers' compensation state fee schedule adj
- B13-Payment for service may have been previously paid
- B15-Procedure/service is not paid separately

Disputed DOS: 7/19/07
Disputed CPT code(s): 97035, G0283, 97110
EOB dated 8/30/07:

- 18-Duplicate claim/service
- R1-Duplicate billing

EOB dated 12/5/07:

- 074-Denied per IME
- 50-Service not deemed "Medically Necessary" by payer
- W4-No additional payment allowed after review.

Disputed DOS: 7/20/07
Disputed CPT code(s): 97002, J1100, 97035, G0283, 97110
EOB dated 8/30/07:

- 074-Denied per IME
- W1-Workers' compensation state fee schedule adj
- 107-Denied due to qualifying service not identified
- W11-Entitlement to benefits. Not finally adjudicated

EOB dated 11/2/07:

- B22-Payment adjusted based on diagnosis
- W4-No Additional payment allowed after review
- Per IME original injury has resolved, claimant is treating for degenerative conditions which are not related to original injury

Disputed DOS: 8/1/07
Disputed CPT code(s): 90806, 90880
EOB dated 9/27/07:

- 074-Denied per IME
- R88-CCI, mutually exclusive procedure
- W1-Workers' compensation state fee schedule adj
- B15-Procedure/service is not paid separately

Disputed DOS: 8/8/07
Disputed CPT code(s): 90806, 90880, 90889, 96151
EOB dated 8/30/07:

- 18-Duplicate claim/service
- R1-Duplicate billing

Issues

1. Does the dispute contain unresolved extent of injury issues?
2. Did the requestor obtain preauthorization of psychology services and physical therapy services as required by Rule 134.600?
3. Does the dispute contain unresolved medical necessity issues?
4. Is the dispute eligible for review by medical fee dispute resolution?
5. Is the requestor entitled to reimbursement?

Findings

1. Does the dispute contain unresolved extent of injury issues?
    - Review of the PLN11 dated 6/20/07 states, "Carrier denies any and all liability and treatment for internal derangement and obesity…."
    - Review of the PLN11 dated 7/2/07 states "Carrier has denied liability and treatment for meniscal degeneration, cartilage loss, bone on bone articulation, subchondral sclerosis, bone edema & behavioral health problems…SORM will pay reasonable and necessary for the knee contusion only. SORM accepts no other injuries at this time…."
    - Review of the CCH decision dated June 9, 2009 indicates that the claimant sustained a compensable bilateral knees contusion injury on July 14, 2005 and does not include depression and degenerative joint disease of both knees.
    - Review of the CMS-1500's and the EOB's all indicated the requestor billed with diagnosis 844.9. Diagnosis code 844.9 is defined as "sprain and strain of unspecified site of knee and leg."
    - The disputed charges are eligible for review by the medical fee dispute resolution section, due to the resolution of the extent of injury issues.

2. Did the requestor obtain preauthorization of psychology services and physical therapy services as required by Rule 134.600?
    - Review of the preauthorization # 628719 & 628719FO, dated June 12, 2007 indicates the requestor obtained preauthorization for outpatient individual psychotherapy (IPT) (1) time per week for (3) weeks, as related to the left knee, diagnosis 717 (Internal derangement of knee). The preauthorization letter also indicates that the requesting provider has represented to Forte that the authorized services will be initiated within the next 30 days and this representation was a material factor in the determination that the services were medically necessary.
    - Review of the preauthorization #631211FO, dated July 13, 2007 indicates the requestor obtained preauthorization for outpatient individual psychotherapy one (1) time a week for (3) three weeks as related to the both knees.
    - Review of preauthorization #633652, dated August 14, 2007 indicates the requestor obtained preauthorization for outpatient individual psychotherapy one (1) time a week for six (6) weeks as related to both knees. The preauthorization letter states in part, "The claimant has completed six sessions of IPT with some progress reported. The request is for six additional sessions to treat the depression and stress related to the injury. The ODG recommends IPT for the treatment of depression and stress…The requesting provider has represented to Forte that the authorized services will be initiated within the next 30 days and this representation was a material factor in the determination that the services were medically necessary…."

3. Does the dispute contain unresolved medical necessity issues?

    The following dates of service were denied / reduced by the carrier due to medical necessity issues.
    - DOS 5/21/07-CPT code 97001-No preauthorization # noted on the CMS-1500

      CPT code 97001 is defined as a physical therapy evaluation and does not require preauthorization, however is subject to a retrospective review. Due to the insurance carrier's denial of medical necessity, Rule 133.305 (b) requires the resolution of the medical necessity issues prior to the submission of a medical fee dispute in accordance with Labor Code §413.031 and §408.021.
    - DOS 5/31/07- CPT codes G0283, 97530, 97535- Preauthorization #627676F0 indicated on CMS-1500

      The Requestor did not include a copy of preauthorization #627676FO to support that the disputed services were preauthorized. Due to the denial of medical necessity for CPT code G0283, Rule 133.305 requires the resolution of the medical necessity issues prior to the submission of the a medical fee dispute in accordance with Rule 133.305 and Labor Code §413.031 and §408.021.
    - DOS 6/7/07-CPT codes G0283, 97035, 97110-Preauthorization #627676F0 indicated on CMS-1500

      The Requestor did not include a copy of preauthorization #627676FO to support that the disputed services were preauthorized. Due to the denial of medical necessity for CPT code G0283, Rule 133.305 requires the resolution of the medical necessity issues prior to the submission of the a medical fee dispute in accordance with Rule 133.305 and Labor Code §413.031 and §408.021.

- DOS 6/29/07-CPT codes 97002, J1100-Preauthorization #628719FO indicated on CMS-1500

  CPT code 97002 and J1100 do not require preauthorization under Rule1 34.600, however are subject to retrospective review. The preauthorization #628719FO does not include authorization for physical therapy re-evaluation and an injection. Due to the insurance carrier's denial of medical necessity, Rule 133.305 (b) requires the resolution of the medical necessity issues prior to the submission of a medical fee dispute in accordance with Labor Code §413.031 and §408.021.

- DOS 7/12/07-CPT codes G0283, 97110-Preauthorization #630752FO indicated on CMS-1500

  The Requestor did not include a copy of preauthorization #627676FO to support that the disputed services were preauthorized. Due to the denial of medical necessity for CPT code G0283, Rule 133.305 requires the resolution of the medical necessity issues prior to the submission of the a medical fee dispute in accordance with Rule 133.305 and Labor Code §413.031 and §408.021.

- DOS 7/13/07-CPT codes 97035, G0283, 97110- Preauthorization #630752FO indicated on CMS-1500

  The Requestor did not include a copy of preauthorization #627676FO to support that the disputed services were preauthorized. Due to the denial of medical necessity for CPT code G0283, Rule 133.305 requires the resolution of the medical necessity issues prior to the submission of the a medical fee dispute in accordance with Rule 133.305 and Labor Code §413.031 and §408.021.

- DOS 7/19/07-CPT codes 97035, G0283, 97110- Preauthorization #630752FO indicated on CMS-1500

  The Requestor did not include a copy of preauthorization #627676FO to support that the disputed services were preauthorized. Due to the denial of medical necessity for CPT code G0283, Rule 133.305 requires the resolution of the medical necessity issues prior to the submission of the a medical fee dispute in accordance with Rule 133.305 and Labor Code §413.031 and §408.021.

- Under Rule 134.600(p)(5), physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (A) Level I code range for Physical Medicine and Rehabilitation, but limited to: (i) Modalities, both supervised and constant attendance; (ii) Therapeutic procedures, excluding work hardening and work conditioning require preauthorization. The preauthorization letters submitted by the Requestor do not cover the physical therapy codes 97035, 97110, 97530 and 97535 listed above, therefore since preauthorization was required and insufficient documentation was submitted to support that preauthorization was obtained, $0.00 reimbursement is recommended to the requestor for the PT codes listed above.

- Under Rule 134.600 (p) (7), physical and occupational therapy services require preauthorization. The preauthorization letters submitted by the Requestor do not cover the physical and occupational therapy services listed above. Therefore, since preauthorization was required and insufficient documentation was submitted to support that preauthorization was obtained, $0.00 reimbursement is recommended to the Requestor for the physical and occupational therapy services listed above.

4. Is the dispute eligible for review by medical fee dispute resolution?

   - Under the provisions of Rule 134.600, CPT codes 97001 rendered on 5/21/08, CPT codes 97002 and J1100 rendered on 6/29/07 do not require preauthorization, therefore are subject to retrospective review. The insurance carrier denied the charge due to unnecessary medical, the preauthorization letters submitted by the Requestor were insufficient to support that these services were preauthorized. Therefore under the provisions of Rule 133.305, the services denied due to unnecessary medical require an IRO review for determination of medical necessity prior to the submission of the medical fee dispute resolution. The remaining charges are eligible for review by the Medical Fe e Dispute Resolution Section.

5. Is the requestor entitled to reimbursement?

- DOS 5/18/07-CPT code 90801-No EOBs were submitted by the Requestor and insufficient documentation was submitted to support that the Requestor made an attempt to request the EOBs as required by Rule 133.307. Therefore, reimbursement cannot be recommended, as the division is unable to determine the reasons for the denial and/or reduction. As a result, no reimbursement is recommended.
- DOS 6/14/07-CPT code 97110- Preauthorization #627676FO indicated on CMS-1500;

  DOS 6/15/07-CPT codes 97035, G0283 and 97110- Preauthorization #627676FO indicated on CMS-1500;

  DOS 6/20/04-CPT codes 97035, G0283 and 97110- Preauthorization #627676FO indicated on CMS-1500.

  The Requestor did not include a copy of preauthorization #627676FO to support that the disputed services were preauthorized. Due to the denial of medical necessity for CPT code G0283, Rule 133.305 requires the resolution of the medical necessity issues prior to the submission of the a medical fee dispute in accordance with Rule 133.305 and Labor Code §413.031 and §408.021. Under Rule 134.600 (p) (7), physical and occupational therapy services require preauthorization. The preauthorization letters submitted by the Requestor do not cover the physical and occupational therapy services listed above. Therefore, since preauthorization was required and insufficient documentation was submitted to support that preauthorization was obtained, $0.00 reimbursement is recommended to the Requestor for the physical and occupational therapy services listed above.
- DOS 6/21/07-CPT codes 90806, 90880, 97035 and G0283- Preauthorization #628719FO & 627676FO

  The Requestor obtained preauthorization for outpatient individual psychotherapy under Preauthorization # 628719FO for diagnosis 717-internal derangement of knee. The CCH decision indicates that derangement of knee is not part of the compensable injury. The EOBs and CMS-1500s indicate the requestor billed with diagnosis 844.9- sprain and strain of unspecified site of knee and leg which is the compensable injury. Reimbursement is not recommended since preauthorization was obtained and approved by the carrier for diagnosis code 717 not 844.9.

  The Requestor did not include a copy of preauthorization #627676FO to support that the disputed services were preauthorized. Due to the denial of medical necessity for CPT code G0283, Rule 133.305 requires the resolution of the medical necessity issues prior to the submission of the a medical fee dispute in accordance with Rule 133.305 and Labor Code §413.031 and §408.021. Under Rule 134.600 (p) (7), physical and occupational therapy services require preauthorization. The preauthorization letters submitted by the Requestor do not cover the physical and occupational therapy services listed above. Therefore, since preauthorization was required and insufficient documentation was submitted to support that preauthorization was obtained, $0.00 reimbursement is recommended to the Requestor for the physical and occupational therapy services listed above.
- DOS 7/6/07-CPT codes 90806, 90880 and 96151- Preauthorization #628719-FO

  The Requestor obtained preauthorization for outpatient individual psychotherapy under Preauthorization # 628719FO for diagnosis 717-internal derangement of knee. The CCH decision indicates that derangement of knee is not part of the compensable injury. The EOBs and CMS-1500s indicate the requestor billed with diagnosis 844.9- sprain and strain of unspecified site of knee and leg which is the compensable injury. Reimbursement is not recommended since preauthorization was obtained and approved by the carrier for diagnosis code 717 not 844.9.
- DOS 7/17/07-CPT codes 90806, 90880 - Preauthorization #631221FO

  DOS 8/1/07-CPT codes 90806, 90880- Preauthorization #631221FO

  DOS 8/8/07-CPT codes 90806, 90880and 96151- Preauthorization #631221FO

  The Requestor did not include a copy of preauthorization #631221FO to support that the disputed services were preauthorized. Under Rule 134.600 (p) (7), physical and occupational therapy services require preauthorization. The preauthorization letters submitted by the Requestor do not cover the physical and occupational therapy services listed above. Therefore, since preauthorization was required and insufficient documentation was submitted to support that preauthorization was obtained, $0.00 reimbursement is recommended to the Requestor for the physical and occupational therapy services listed above.
- DOS 7/20/07-CPT codes 97002, J1100, 97035, G0283 and 97110- Preauthorization #630752FO

  The Requestor did not include a copy of preauthorization #630752FO to support that the disputed services were preauthorized. Under Rule 134.600 (p) (7), physical and occupational therapy services require preauthorization. The preauthorization letters submitted by the Requestor do not cover the physical and occupational therapy services listed above. Therefore, since preauthorization was required and insufficient documentation was submitted to support that preauthorization was obtained, $0.00 reimbursement is recommended to the Requestor for the physical and occupational therapy services listed above.

Conclusion

For the reasons stated above, the division finds that the requestor has failed to establish that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services involved in this dispute.

Authorized Signature	Margaret Q. Ojeda Medical Fee Dispute Resolution Officer	Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.